

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2016
NAME OF PROVIDER OR SUPPLIER HAZEL'S HOME CARE SOLUTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 707 PIEDMONT STREET REIDSVILLE, NC 27320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments Report by Paul Dixon DHSR Construction Section conducted a Biennial Survey on January 20, 2016 from 1:00 PM to 2:15 PM at the above referenced facility. DHSR records indicate the home was first licensed on March 31, 2009 as a Family Care Home for six (6) ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 2005 Rules 10A NCAC 13G for Family Care Homes, the 2009 North Carolina State Building Code - Section 421.2 - Residential Care Homes. At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:	C 000		
C 174	Building Equipment Maintained Safe, Operating SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: Observations during the survey showed that in the left front bedroom, there are two oxygen bottles which are not stored in an approved rack. Contact your oxygen provider and obtain the proper storage rack for the oxygen bottles. Provide the DHSR Construction section with	C 174		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2016
NAME OF PROVIDER OR SUPPLIER HAZEL'S HOME CARE SOLUTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 707 PIEDMONT STREET REIDSVILLE, NC 27320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 174	Continued From page 1 copies of all invoices, work orders, receipts, photographs and any other supporting documentation concerning this repair.	C 174			